

COMMONWEALTH OF VIRGINIA DEPARTMENT OF SOCIAL SERVICES APPLICATION/REDETERMINATION FOR MEDICAID FOR SSI RECIPIENTS	AGENCY USE ONLY		
	CASE NAME		LOCALITY
	CASE NUMBER	WORKER	DATE RECEIVED

A. IDENTIFYING INFORMATION	
NAME: _____ SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ ADDRESS: _____ TELEPHONE NUMBER: _____ MARITAL STATUS: NEVER MARRIED _____ MARRIED _____ SEPARATED _____ WIDOWED _____ DIVORCED _____ SEX: _____ COUNTRY OF ORIGIN: _____ CITIZEN/ALIEN STATUS: _____ LANGUAGE (Enter Code): _____ 1 - English 2 - Spanish 3 - Cambodian 4 - Vietnamese 5 - Farsi 6 - Haitian-Creole 7 - Laotian 8 - Chinese 9 - Korean A - Somali B - Kurdish C. - Arabic F - French G - German J - Japanese O - Other RACE (Enter Code): _____ 1 - White 2 - Black/African-American 3 - American Indian/Alaskan Native 4 - Asian 5 - Native Hawaiian/Other Pacific Islander 6 - American India/Alaskan Native and White 7 - Asian and White 8 - Black/African-American and White 9 - American Indian/Alaskan Native and Black/African-American A - Asian and Black B - Other ETHNICITY (Enter Code): _____ 1 - Hispanic or Latino 2 - Not Hispanic or Latino	
B. ADDITIONAL INFORMATION	
<div style="text-align: right;">CIRCLE ONE</div> <div> 1. I AM A RESIDENT OF VIRGINIA. YES NO </div> <div> 2. I RECEIVE A SUPPLEMENTAL SECURITY INCOME (SSI) CHECK. YES NO </div> <div> 3. I OWN, HAVE AN INTEREST IN, OR HAVE INHERITED REAL PROPERTY (LAND OR BUILDINGS). YES NO </div> <div> TYPE OF PROPERTY: _____ ACREAGE: _____ VALUE: \$ _____ LOCATION: _____ </div> <div> 4. I HAVE OTHER RESOURCES SUCH AS LIVESTOCK, CAR, TRUCK, CAMPER, MOBILE HOME, RETIREMENT ACCCOUNT, LIFE INSURANCE, BANK ACCOUNT, STOCKS, BONDS, SAVINGS CERTIFICATES, PATIENT FUND ACCOUNT, TRUST FUNDS, CASH, BURIAL PLOTS, OR BURIAL ARRANGEMENTS. YES NO </div> <div> RESOURCE: _____ VALUE: _____ RESOURCE: _____ VALUE: _____ RESOURCE: _____ VALUE: _____ </div> <div> 5. I HAVE SOLD, TRADED, OR GIVEN AWAY ASSETS (LAND, BUILDINGS, BANK ACCOUNTS, MONEY, CARS, STOCKS, TRUST FUNDS, INCOME, ETC.) DURING THE PREVIOUS 60 MONTHS. YES NO </div> <div> WHEN: _____ TO WHOM: _____ WHAT: _____ AMOUNT RECEIVED: \$ _____ </div> <div> 6. I HAVE MEDICARE. YES NO </div> <div> MEDICARE #: _____ PART A EFFECTIVE DATE: _____ PART B EFFECTIVE DATE: _____ </div> <div> 7. I HAVE OTHER HEALTH INSURANCE. YES NO </div> <div> COMPANY NAME: _____ POLICY #: _____ TYPE OF COVERAGE: _____ EFFECTIVE DATE: _____ </div> <div> 8. I LIVE IN A NURSING FACILITY OR STATE INSTITUTION. YES NO </div> <div> IF YOU STILL OWN YOUR HOME, WHO LIVES IN IT. _____ (NAME AND RELATIONSHIP) </div> <div> 10. I RECEIVED MEDICAL CARE DURING THE THREE MONTHS BEFORE THIS APPLICATION. YES NO </div> <div> FROM: _____ DATE: _____ </div>	

RIGHTS AND RESPONSIBILITIES

I UNDERSTAND THAT I MUST REPORT ANY CHANGES THAT OCCUR IN MY SITUATION TO THE DEPARTMENT OF SOCIAL SERVICES WITHIN TEN DAYS. I AGREE TO ASSIGN MY RIGHTS TO MEDICAL SUPPORT AND OTHER THIRD-PARTY PAYMENTS TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES, EFFECTIVE WITH MY COVERAGE UNDER MEDICAID. ALL MONEY I RECEIVE FOR (1) DIAGNOSIS OR TREATMENT OF ANY INJURY, DISEASE OR DISABILITY OR (2) MEDICAL CARE SUPPORT MUST BE SENT TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES, THIRD PARTY LIABILITY SECTION. I UNDERSTAND REFUSAL TO ASSIGN MY RIGHTS WILL MAKE ME INELIGIBLE FOR MEDICAID.

I UNDERSTAND THAT I HAVE THE RIGHT TO FILE A COMPLAINT IF I FEEL I HAVE BEEN DISCRIMINATED AGAINST BECAUSE OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE, HANDICAP, OR RELIGIOUS BELIEF. I UNDERSTAND THAT I HAVE THE RIGHT TO APPEAL AND HAVE A FAIR HEARING IF I AM (1) NOT NOTIFIED IN WRITING OF THE DECISION REGARDING MY APPLICATION WITHIN 45 DAYS; (2) DENIED MEDICAID; OR (3) DISSATISFIED WITH ANY OTHER DECISION THAT AFFECTS MY RECEIPT OF MEDICAID. I UNDERSTAND THAT REFUSAL TO COOPERATE WITH A REVIEW OF MY MEDICAID ELIGIBILITY BY QUALITY CONTROL WILL MAKE ME INELIGIBLE FOR MEDICAID UNTIL I COOPERATE WITH THE REVIEW.

I AUTHORIZE THE DEPARTMENT OF SOCIAL SERVICES AND THE DEPARTMENT OF MEDICAL ASSISTANCE TO OBTAIN ANY VERIFICATIONS NECESSARY TO ESTABLISH MY ELIGIBILITY FOR ASSISTANCE. I AUTHORIZE RELEASE TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES ANY INFORMATION IN ANY MEDICAL RECORDS PERTAINING TO ANY SERVICES RECEIVED BY ME AS A BENEFIT UNDER MY MEDICAL ASSISTANCE (MEDICAID) ELIGIBILITY.

I RECEIVED THE BOOKLETS: MEDICAID HANDBOOK [] YES [] NO BENEFIT PROGRAMS [] YES [] NO
I FILLED IN THIS FORM MYSELF. [] YES [] NO IF NO, IT WAS READ BACK TO ME WHEN COMPLETED. [] YES [] NO

I DECLARE THAT ALL INFORMATION I HAVE GIVEN ON THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT IF I GIVE FALSE INFORMATION, WITHHOLD INFORMATION, OR FAIL TO REPORT A CHANGE PROMPTLY OR ON PURPOSE, I MAY BE BREAKING THE LAW AND COULD BE PROSECUTED FOR PERJURY, LARCENY, AND/OR WELFARE FRAUD. I UNDERSTAND THAT MY SIGNATURE ON THIS APPLICATION CERTIFIES, UNDER PENALTY OF PERJURY, THAT I AM A U.S. CITIZEN OR ALIEN IN LAWFUL IMMIGRATION STATUS.

SIGNATURE OR MARK: _____ DATE: _____

WITNESS/AUTHORIZED REPRESENTATIVE: _____ DATE: _____

I COMPLETED THIS APPLICATION/REDETERMINATION FOR _____. I UNDERSTAND THAT IF I AIDED OR ABETTED THIS INDIVIDUAL IN OBTAINING ASSISTANCE FOR WHICH HE IS NOT ELIGIBLE, THAT I MAY BE BREAKING THE LAW AND COULD BE PROSECUTED.

SIGNATURE: _____ RELATIONSHIP: _____ DATE: _____
ADDRESS: _____ TELEPHONE#: _____

VOTER REGISTRATION

AS A CITIZEN OF THE COMMONWEALTH OF VIRGINIA, WE ARE REQUIRED TO PROVIDE YOU WITH THE OPPORTUNITY TO REGISTER TO VOTE WHEN APPLYING FOR BENEFITS. PLEASE CHECK ONE OF THE FOLLOWING:

IF YOU ARE NOT REGISTERED TO VOTE WHERE YOU LIVE NOW, WOULD LIKE TO REGISTER TO VOTE TODAY?

- ☐ YES, I WOULD LIKE TO REGISTER TO VOTE. (IF YOU WOULD LIKE HELP FILLING OUT THE VOTER REGISTRATION APPLICATION FORM, WE WILL HELP YOU. THE DECISION TO ACCEPT HELP IS YOURS. YOU ALSO HAVE THE RIGHT TO FILL OUT YOUR VOTER REGISTRATION APPLICATION FORM IN PRIVATE.)
- ☐ I DO NOT WANT TO APPLY TO REGISTER TO VOTE TODAY.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

APPLYING TO REGISTER OR DECLINING TO REGISTER TO VOTE WILL NOT AFFECT THE AMOUNT ASSISTANCE OR SERVICES THAT YOU WILL BE PROVIDED BY THIS AGENCY. IF YOU BELIEVE THAT SOMEONE HAS INTERFERED WITH YOUR RIGHT TO REGISTER OR TO DECLINE TO REGISTER TO VOTE, YOUR RIGHT TO PRIVACY IN DECIDING WHETHER TO REGISTER TO VOTE, OR YOUR RIGHT TO CHOOSE YOUR OWN POLITICAL PARTY OR OTHER POLITICAL PREFERENCE, YOU MAY FILE A COMPLAINT WITH: SECRETARY OF THE VIRGINIA STATE BOARD OF ELECTIONS, NINTH STREET OFFICE BUILDING, 200 NORTH NINTH STREET, RICHMOND, VA 23219-3497, (804) 786-6551.

AGENCY USE ONLY: FACE-TO-FACE INTERVIEW NOT REQUIRED. A VOTER REGISTRATION FORM WAS MAILED.

		**AGENCY USE ONLY **		*	
A.	ELEMENTS OF EVALUATION	VERIFICATION/PERTINENT INFORMATION		MEETS ELIGIBILITY REQUIREMENTS	
1.	VA RESIDENCY, IF QUESTIONABLE	_____		YES	NO
2.	RECEIVES SSI CHECK	SDX _____	SVES _____ OTHER _____	YES	NO
If no, have the individual complete the Application for Benefits.					
3.	SSI CONDITIONAL/PRESUMPTIVE	_____		YES	NO
4.	ASSET TRANSFER	_____		YES	NO
5.	RESOURCES (IF HAS A TRUST OR OWNS UNDIVIDED HEIR PROPERTY, CONTIGUOUS PROPERTY, FORMER HOME, OR OTHER REAL PROPERTY)	_____ _____			
	VALUE OF COUNTABLE RESOURCES	\$ _____		YES	NO
B.	RECOMMENDATION				
1.	CURRENT ELIGIBILITY:	ELIGIBLE: _____	EFFECTIVE DATE: _____	INELIGIBLE _____	
2.	RETROACTIVE ELIGIBILITY:	ELIGIBLE: _____	EFFECTIVE DATE: _____	INELIGIBLE _____	
WORKER'S SIGNATURE: _____		DATE: _____			
SUPERVISOR'S SIGNATURE: _____		DATE: _____			
C.	ENROLLMENT				
SPEC REVIEW: _____ CTY: _____ Cl: _____ BEGIN: _____ END: _____ TYPE: _____					
PD: 11 _____ 31 _____ 51 _____ APP DATE: _____ MEDICAL RESOURCE: _____ TYPE COV: _____					
INS CO: _____ POLICY NUMBER: _____ BEGIN DATE: _____ END DATE: _____					